**ANNEX A**

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Basildon Hospital Trust.**<br>**Nethermayne**<br>**Basildon**<br>**Essex.**<br>**SS17 0SS.** |
| 1 | **CORONER**<br><br>I am Mrs Eleanor McGann HM Area Coroner, for the area of Essex |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3 | **INVESTIGATION and INQUEST:**<br><br>**On the 31st July 2015 I commenced an investigation into the death of Mr Roy Henry Oakley who was 82 years old having been born on the 5th December 1932. The investigation concluded at the end of the inquest on the 23rd March 2016. The conclusion of the inquest was that Mr Oakley's death was an Accident.** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>**Mr Oakley had been taken to Orsett Hospital by Thames Ambulance Service (TAS) for a routine blood test. No settled arrangement was made for his collection by TAS rather he was told to wait in the coffee shop. Mr Oakley, who suffered from Dementia, left the coffee shop and went to the Ambulance Bays to try to find who was taking him home. There he suffered an accident as a result of which he died on the 12th June 2015.** |
| 5 | **<u>CORONER'S CONCERNS</u>**<br><br>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. – |

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| | TAS had not been told that Mr Oakley suffered from Dementia and nobody had arranged for a Carer to attend with him. During the course of the inquest it emerged that the Phlebotomy Service who arranged the transport, were unaware that Mr Oakley had Dementia. The Phlebotomy Service is, commissioned out to a private company by Basildon Hospital and they do not have access to Basildon Hospitals Record Keeping System which flagged up Mr Oakley's Dementia. Other commissioned out services are in a similar position. The failure to communicate and the lack of information sharing may have played some part in the death of Mr Oakley. |
| He | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th May 2016. I, the coroner, may extend the period.<br><br>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. |
| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons.<br><br>Basildon & Thurrock University Hospital NHS Foundation Trust<br>Basildon Hospital<br>Mr Henry Oakley's Family<br>Thames Ambulance Service (TAS)<br>East of England Ambulance Service<br>NELFT – North East London NHS Foundation Trust |
| 9 | **1st April 2016.** **Mrs Eleanor McGann** |